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Grief Experiences Of Widowed Women Based On Length Of Bereavement

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GRIEF EXPERIENCES OF WIDOWED WOMEN

BASED ON LENGTH OF BEREAVEMENT

by

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Abstract

Death of a spouse is a stressful life event that carries the increased threat of illness developing as a consequence. Spousal loss is a situation that primarily affects women because women usually live longer than men and most wives are younger than their husbands. As widowhood affects more women then men, there is a need for understanding patterns of grief reactions in women. The focus of this descriptive study was to compare the differences in grief experiences of widowed women based on length of bereavement. The purpose of this study was to examine the differences in grief experiences by women who lost their spouse 6 months to 2 years and over 2 years to 4 years prior to the study. The Neuman Systems Model was used as the theoretical framework for this study. The research question for this study was as follows: Is there a difference in grief experiences by women who lose their spouse over varying periods of time. The convenience sample consisted of 20 individuals between the ages of 32 and 86 years. Data were collected using the Revised Grief Experience Inventory and a demographic survey. Data were

analyzed using descriptive statistics and a two-tailed t test to compare differences between the groups. Findings from the data analysis indicated there was no significant difference in grief experiences of widowed women based on length of time since bereavement. An open-ended question was included on the demographic survey which asked participants to share anything that might help someone else who loses a spouse. The two common themes that were identified as a result of this question were spirituality and lapse of time. Conclusions drawn from the study included no difference in grieving experiences when comparing these groups of rural widows based on length of time since bereavement. Also, a majority of the widowed women expressed reliance on spirituality. Several recommendations for nursing practice, education, and research were made as a result of the study. Nursing practice recommendations included utilization of an assessment tool to determine if there are any particular areas of grieving that are especially problematic for the widow. Nursing education recommendations included incorporation of discussion and explanation of patterns of grief reactions for widowed women. Further research was

recommended, particularly in the area of understanding patterns of grief reactions among diverse populations of widows living in various geographic locations.

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Chapter I

The Research Problem

Death of a spouse is a stressful life event that carries the increased threat of developing an illness for the survivor. Spousal loss primarily affects women since women usually live longer than men and most wives are younger than their husbands. Therefore, widowhood affects more women than men. Indeed, three out of four married women will become widowed (Poncar, 1989). The transition of wife to widow is a complex process, but it is necessary and is characterized by a role change that takes place over time (Silverman, 1986). The widow must cope with the loss, accept new responsibilities and tasks, and redefine her new role (Poncar, 1989). As widowhood affects more women than men, there is a need for understanding patterns of grief reactions in women. The focus of this descriptive study was to compare the differences in grief experiences of widowed women based on length of bereavement.

Establishment of Problem

Grief is a psychological and physiological process that occurs with a specific loss, such as death of a loved one (Rando, 1986). Those who experience the death of a spouse experience one of the most painful and stressful situations in life (Henderson, 1994). The U.S. Census Bureau states that of the 195,568 individuals aged 18 or older, the male widow comprises 2,686 or 2.9% of the total population, and the female widow comprises 11,056 or 10.9%. Therefore, the total number of widow(er)s of the total married population age 18 years and older number 13,743. As age increases, the number and percentage of women who are widows also increase (Hobbs, 1997).

The death of a spouse may have a profound impact on the surviving partner, especially for those who have been married for a long time. Marriage vows imply "till death do us part" (Lief, 1997). However, death of a spouse is usually not thought about until the survivor is faced with the situation and may involve loss of a best friend, a lover, a companion, or a provider. Grieving, in part, can depend on the relationship that the couple had during marriage, what the spouse meant to the survivor, and the nature of the events surrounding the death (Goodall,

Drage, & Bell, 1995). If the relationship was a close one, grieving could take a long time to overcome.

Feelings such as sorrow, sadness, and a profound sense of loss are a part of the grief experienced with the death of a spouse. These feelings may be accompanied by tearfulness and crying and may be referred to by some as pain. There is no right or wrong way to grieve, mourn, or feel. Individuals cope with grief in different ways. Some people appear not to grieve the loss of a loved one. These people who seem not to be grieving may be doing so in private or may have a strong will to appear as a coping individual. In other instances, some individuals may feel as though they have already done their grieving. If the spouse who died was in pain or had a diminished quality of life, the death may bring more relief than sorrow to the survivor (Henderson, 1994). People are affected differently, according to their personality, the nature of the relationship, and previous coping mechanisms (Goodall et al., 1995). If the partner had been independent during the marriage, the grieving process might be less intense.

The process of grief involves a number of tasks for adjustment and growth after the loss. Several researchers have identified various tasks or stages of grief. Worden

(1991) identified four tasks of grieving which include acceptance of the loss, experiencing the pain, adjusting to an environment without the deceased, and letting go. Successful grieving requires the completion of all four tasks (Worden, 1991).

Parkes (1972) studied grief following illness and death and identified different stages of grief which blend into and replace one another. The first stage is the initial or alarm phase and is characterized by physical distress. Crying is a common emotional reaction that occurs. The widow may be physically and emotionally exhausted. Widows also may report not feeling healthy. Studies have documented increased morbidity during bereavement (Lund, 1989).

The next stage is characterized by pining, yearning, anger, and tension and guilt. In this phase, the widow may experience angry feelings and guilt feelings. The widow may feel guilt because her spouse was taken and she was spared.

As time passes, there may remain episodes of depression. Widows frequently report feeling depressed. Symptoms of depression include crying easily, difficulty concentrating, feeling extremely anxious and unsettled,

frequent mood changes, and small problems become overwhelming.

The last stage of grief, according to Parkes (1972), is recovery and is characterized by the survivor's ability to find a new identity and a new meaning in life or addresses existential concerns. A widow may feel that life seems empty and barren. The loss of a spouse is an emotional and social loss. Major changes are required in lifestyle and role performance (Parkes & Weiss, 1983). Therefore, the widow must adapt to a new reality, a new identity, and a new life.

Various factors may impact the different stages of grief. The intensity of grief in each stage may be affected by several variables identified by experts in the field (Grimby, 1995; Lund, Caserta, & Dimond, 1993). Health may be affected by grief reactions which may trigger feelings of despair, depression, and personal worthlessness (Bower, 1997). One kind of grief that may follow death of a family member is complicated grief which is difficult to define since there are significant variations within the normal grief process (Goodall et al., 1995). Abnormal grief reactions and complicated grief appear to promote intolerable emotional pain that is

accompanied by suicidal thoughts and deepening depression (Joffrion & Douglas, 1994).

Support systems for bereaved individuals may affect the intensity and impact of grief. Most widows obtain emotional, social, and practical support from a network of relatives and friends (Bowling & Cartwright, 1982). Children can be an important source of support to widows, and many help the bereaved individuals cope with their loss.

Other factors have been identified that may also affect the grieving process. These factors include paid employment experience, religious affiliation, and length of time since spousal death. A history of paid work experience during a woman's married years may serve as a health protection after she has become widowed (Aber, 1992). Religious affiliation has been identified as a significant predictor of lower grief intensity (Meuser, Davies, & Marwit, 1995). Additionally, other losses encountered during widowhood may impact grief. Examples of these losses include a decrease in finances, death of other family members or close friends, loss or gain of a job, or a move from where the widow once lived before the death of the spouse.

Grief is a universal event that affects all ages and cultures. Grief affects various individuals differently, depending on several factors. In the case of widows, the intensity of grief seems to decrease as the time from spousal death increases (Hyrkas, Kaunonen, & Paunonen, 1997). However, no research studies have identified whether certain manifestations of grief, such as depression, physical distress, existential tension, or tension and guilt, decrease in a specific order or at what rate of intensity over time.

Assumptions

For the purposes of this study, the following assumptions were made:

1. Women experience grief after the death of a husband.

2. Spousal death is a stressor.

3. The Revised Grief Experience Inventory accurately measures women's grief.

Problem Statement

Death of a spouse is a stressful life event that carries the increased threat of illness developing as a consequence. Many women will face this extremely stressful

life event. The focus of this study was to examine the differences of grief experienced by women who had lost their spouse 6 months to 2 years and over 2 years to 4 years prior to the study.

Research Questions

This study was guided by one research question: Is there a difference in grief experienced by women who lost their spouse over varying periods of time?

Definition of Terms

For the purposes of this study, four terms were defined. Those terms are as follows:

Grief experience: Theoretical: an emotional response that occurs after the loss of a loved individual (Taber's Cyclopedic Medical Dictionary, 1997). Operational: a participant's response to the death of husband as determined by the Revised Grief Experience Inventory.

Women: Theoretical: adult females (American Heritage Concise Dictionary, 1994). Operational: surviving female spouses over the age of 21 years living in a rural southern state who consented to participate in the study.

Spouse: Theoretical: one's husband or wife (American Heritage Concise Dictionary, 1994). Operational: a person to whom the participant has been married and is deceased.

Varying periods of time: Theoretical: different intervals between an occurrence of a phenomenon measured by duration (American Heritage Concise Dictionary, 1994). Operational: the time intervals since the death of a spouse of 6 months to 2 years and over 2 years to 4 years.

Theoretical Framework

The theoretical framework for this study was the Neuman Systems Model (Neuman, 1989). Neuman's major concepts include client and client systems that are a dynamic composite of physiological, psychological, sociocultural, developmental, and spiritual variables. Neuman's model consists of a series of rings that surround and protect the core of the individual. The series of rings that surround the individual are lines of defense. The flexible lines of defense serve as the outer ring, the normal lines of defense serve as the secondary stable ring, and the lines of resistance surround the individual. The similarities of the rings are that each one contains elements of the five variables that build the individual (physiological, psychological, developmental,

sociocultural, and spiritual) while each ring has a different function of protection. In widowed women, the five variables that make up the individual have the potential for becoming unstable due to the stressful life event of spousal death.

The flexible lines of defense serve to protect the individual in the normal or stable state. The flexible lines of defense also prevent invasion of stressors and keep the client system free of stressors, reactions, and symptomatology, but can quickly deteriorate in emergency situations or illness. A support system utilized by widows may strengthen the flexible lines of defense, which may prevent invasion of stressors during spousal death. A support system, such as family, friends, church, and health care providers, can assist, counsel, support, and educate widowed women. If a support system is not utilized, the flexible lines of defense may be weakened.

The normal line of defense is a solid boundary line that surrounds the perforated lines of resistance. The line of defense represents what the individual has become through life and represents one's usual state of wellness. The stability and the integrity of the normal line of defense are conveyed by the ability of the client's system

to adjust to environmental stressors. The normal line of defense can remain unchanged, strengthened by effective use of support systems, or weakened by ineffective use of support systems. Like the flexible line of defense, the normal line of defense is affected by a change in the system variables, coping patterns, lifestyle factors, and developmental and spiritual influences. When ineffectively protected by the flexible line of defense, a stressor may create a reaction from the individual. The normal line of defense is dynamic in that its stability may be strengthened after adjustment to a stressor reaction leading to more resistance to similar stressors (Neuman, 1989).

The lines of resistance are the innermost barriers and surround the individual. The lines of resistance attempt to invade the stability of the client system and foster a return to normal. If the lines of resistance are unable to stabilize the client and client system, death will occur. If a woman utilizes various sources of support, including a family nurse practitioner, to assist, counsel, support, and educate, the lines of resistance could be built up to prevent invasion and stability would

remain. Thus, the client and client system would be stable and death would be decreased.

According to Neuman (1989), intervention is known as prevention. Interventions for grieving widows may be initiated by friends, remaining family members, or the primary health care provider, such as a family nurse practitioner, as soon as a stressor or risk factor is identified. The first step in prevention is primary prevention. Primary prevention is carried out when the stressors or risks have been identified but have not occurred. Primary prevention maintains wellness of the individual by strengthening the flexible and normal lines of defense. The intervention would include decreasing the stressors and increasing the strength of the flexible lines of defense, which are the outer barriers. Secondary prevention is intervention or treatment after symptoms of the stressors occur. Tertiary prevention focuses on optimal client stability. The primary goal of this level is to strengthen resistance to the stressors which prevents a reoccurrence. The goal of prevention as intervention is to retain, attain, and maintain client and client system stability. According to Neuman (1989), support systems could play a role in strengthening lines

of defense of widowed women by assisting, counseling, supporting, and educating. Therefore, family nurse practitioners could play a role in primary and secondary prevention.

Significance to Nursing

Spousal grief experiences of clients impact emotional and physical health. In every day practice a family nurse practitioner can assist, counsel, support, and educate survivors to understand natural grief reactions. Differential diagnoses of normal grief, complicated grief, or a depressive disorder can be made or determined. Sudden recurrences of grief in the surviving spouse may occur and are part of the bereavement process. The recently bereaved may be likely to go to a primary health care practitioner. Therefore, it is important that health professionals be aware that physical symptoms in the recently bereaved are a normal response to grief. Family nurse practitioners must be aware of the stages of grief that a spouse goes through with the loss of a loved one. Knowing and recognizing the stage of grief the client is experiencing will enable the family nurse practitioner to give appropriate help to the client. Family nurse practitioners need to teach clients about the normal grieving process

and potential regression through the grief stages on anniversary dates. Psychotropic drugs are not indicated for normal grief responses as they only delay dealing with the loss of the spouse (Uphold & Graham, 1994). However, appropriate support as well as counseling is important. Family nurse practitioners may need to consult or refer to clergy and support groups as they can play a major role in helping the bereaved.

If the surviving spouse is unable to handle difficult situations, health may succumb to grief. Grief may trigger depression and physical symptoms that may bring the widow into the clinical setting. When grief or some unexplained physical symptoms persist for prolonged periods of time after spousal demise, the possibility of depressive disorder should be considered. As grief may lead to health problems, family nurse practitioners need to know more about bereavement and specific health problems that may ensue. Widowed individuals most commonly report symptoms of arthritis, insomnia, anxiety, and forgetfulness or confusion (Bowling & Cartwright, 1982). The family nurse practitioner should be aware of the possibility that the symptoms experienced during bereavement may be due to a serious physical illness. With knowledge about the time

interval during which certain manifestations of grief occur, the family nurse practitioner could assist, counsel, support, and manage the surviving spouse more effectively.

Summary

Death of a spouse is a stressful event in life that carries a threat of illness occurring as a result. Many women will be confronted with this stressful event. Family nurse practitioners must be aware of grief reactions that are normal and abnormal. The Neuman Systems Model incorporates lines of defense that protect the individual from stressful situations which may penetrate the core of the individual. The stronger the lines of defense, the harder it is to penetrate to the individual. The family nurse practitioner may strengthen these lines of defense by assisting, counseling, supporting, and educating the surviving spouse. If surviving spouses are able to handle this difficult situation, the risk of serious physical illness could be decreased.

Chapter II

Review of the Literature

A review of the literature revealed a scarcity of studies regarding grief. Several studies were identified concerning grief experiences of individuals after the death of a spouse. However, only one study compared grief reactions and the intensity of grief experienced after the death of a spouse over time.

Research has suggested that recovery from spousal death occurs over time. Hyrkas, Kaunonen, and Paunonen (1997) conducted a study which compared grieving women and men who had lost a spouse. The purpose of the study was to discuss the grief reactions and the intensity of experienced grief in Finnish women and men after 8 months to 2 years and over 2 years after spousal death. These researchers sought to determine if there was a difference in the intensity of grief before or after 2 years of the experienced bereavement in women and men.

Hyrkas et al. (1997) focused on the concept of spousal grief. The design of the study was descriptive.

The random samples from two hospitals consisted of women (n = 242) and men (n = 76) who had lost a spouse aged 25 to 65 years at the time of death. Data were gathered using two standardized instruments, a sociodemographic instrument and the Hogan Grief Reactions Checklist. The sociodemographic instrument data included gender and age of the respondent and deceased spouse, cause of spousal death, and attendance of the respondent at bereavement support meetings. The Hogan Grief Reactions Checklist (HGRC) was comprised of 61 items that assessed bereavement. The HGRC was tested in this sample for reliability using Cronbach's alpha test with values varying from 0.651 to 0.829 for different dimensions of grief.

For the bereavement scale on the HGRC, two measures were used. The first measure was a single total score derived by summing the 0 to 4 responses on all items. Before arriving at a composite score, reverse coding was used for negatively coded items. The second measure was used to assess the severity level of symptomatology in each respondent. The intensity of grief was derived for the different dimensions of grief, despair, panic behavior, personal growth, blame and anger, detachment,

and disorganization. A time frame was created in the two subgroups of respondents of less than 2 years and more than 2 years after spousal death. The subgroups of respondents also were divided by gender.

After a response rate of 51.7% (464), 146 questionnaires were rejected for a total sample of 318. In addition, a random sample of volunteers was interviewed at the conclusion of the study. Descriptive statistics were used to interpret the data collected. The SPCC/PC statistical program was used to analyze the data. Hyrkas et al. (1997) found the mean age of the respondents was 56.3 years and mode was 64 years. Hyrkas et al. found statistical significance in the dimension of despair ($p < .05$) and disorganization ($p < .05$) between subgroups of less than 2 years and more than 2 years of bereavement. Within gender difference, statistical significance emerged in the dimension of blame and anger ($p < .05$) when spousal death occurred more than 2 years prior to the study with widowers describing grief more strongly than widows. Also, statistical significance was determined in the dimension of disorganization ($p < .05$) when spousal death occurred more than 2 years prior to the study with widowers feeling less organized than widows.

Hyrkas et al. (1997) concluded that there were significant differences between the two groups in despair and disorganization. These results supported earlier studies that suggested the intensity of grief seemed to decrease as the time from spousal death increased. Hyrkas et al. also concluded that there were no significant differences between women and men in the dimensions of bereavement in the subgroups of less than 2 years since spousal death. However, in the subgroup of more than 2 years since spousal death the researchers found a gender difference in the dimensions of blame and anger and disorganization, with widowers showing the dimensions more than the widows. Hyrkas et al. recommended that a longitudinal study would be more beneficial than the cross-sectional study as a longitudinal study would provide more generalizations about the intensity of grief after spousal death. The researchers also recommended that more research about the bereavement process is needed to more fully understand grief reactions after the death of a spouse.

Hyrkas et al.'s (1997) research is germane to this current researcher's endeavor because it provides the perspective to describe the grieving process by gender and

time. The two studies are alike in several ways. Both studies looked at time frames that are similar. Hyrkas et al.'s time frame was 8 months to 2 years and over 2 years after spousal death, and the current study's time frame was 6 months to 2 years and over 2 years to 4 years after spousal death. The Hyrkas et al. study looked at age groups of 25 to 65 years of age at time of death, and this researcher's study looked at individuals aged 21 years and over at the time of death. However, the studies did have some differences. The first difference was the instruments used to collect data. The Hyrkas et al. study used the Hogan Grief Reactions Checklist while this researcher used the Revised Grief Experience Inventory. Another difference was the Hyrkas et al. study surveyed Finnish men and women, and this researcher surveyed women in the southeastern United States.

A review of the literature indicated that death of a spouse is a stressful life event that puts an individual's health at risk which might be ameliorated by certain variables. Aber (1992) addressed the association between widows' health and the paid work role identity as a resistance resource. The purpose of the study was to examine the paid work role as a critical factor and

determinant of health risk of older widows during their conjugal bereavement. Further, Aber (1992) sought to determine whether the paid work role could be a buffering factor playing a protective role during bereavement as Kohn's theory supported in a previous study.

The underlying premise of the research was that the death of a spouse was a stressful life event which increased the threat of illness developing as a consequence. The hypothesis was work history and work attitude were statistically significant predictors of health during bereavement. Extraneous variables identified by Aber (1992) included prior health, suddenness of death, education/social class, marital satisfaction, social support, and age.

The design of the study was descriptive with the use of a survey. The convenience sample (N = 157) was achieved using recorded death certificates of the surviving spouses of deceased men aged 55 to 75 years. These surviving spouses were bereaved for 2 years prior to the study. Data were gathered using the Widowhood Questionnaire. No existing instruments were found applicable to the specific variables under study. Therefore, an instrument was developed that allowed the variable of interest to be

investigated. Content validity was established through a thorough literature review, and the instrument was tested for reliability with Cronbach's alpha.

The respondents were asked to complete 60 items. Each respondent received a composite score for each of the variable constructs measured. A Likert-type scale or circled response format was used. A response rate of 42.3%, 202 out of 477 questionnaires mailed, was attained.

The mean age of the widows in the Aber (1992) study was 66 years of age. Of the respondents, 76% reported participation in the paid work force during their marriages, and 24% of respondents reported never having been employed during their marital years. A further breakdown of the sample was done to include work history which indicated that 21% of the respondents had been employed full-time but off and on for brief periods of time during their marriages. Of the paid work force respondents, 22% reported employment for longer periods of time, 17% reported they were always employed, and 15% reported being established in a career. The respondents' jobs ranged from blue collar to professional positions.

Work history was assessed on three questionnaire items. Work attitude was assessed on five questionnaire

items. Work history [R^2 = .029, $F(1,156)$ = 4.74, p < .04] and work attitude [R^2 = 0.058, $F(1,156)$ = 9.66, p < .05] were statistically significant predictors of health during bereavement. A step-wise regression analysis was completed to determine which independent variables had the greatest influence in predicting health during bereavement. The better predictor in this study's sample of older women seemed to be work attitude.

Aber (1992) concluded that a history of paid work during a woman's married years may serve as a health protection after she has become widowed. Aber also concluded that women with paid work history may possess internal and external resources to decrease stressful life experiences, such as spousal death, to be less problematic from a health perspective. Thus, paid work role may have lessened the negative impact of spousal death and allowed an easier transition into widowhood.

The findings of this study indicated that paid work role identity has a positive impact on women's health during bereavement. Paid work may have a protective effect on the overall health status of women. Therefore, health care professionals may be directing women toward health-promoting and health-sustained behaviors by encouraging

paid work role (Aber, 1992). Research studies need to be conducted on health-promoting and health-sustained activities following spousal death to promote health in women.

Aber's (1992) study supported this researcher's study since both examined women after spousal death. However, while Aber focused on widows aged 55 to 75 years of age, this researcher focused on widows aged 21 years and older. Another difference in the studies was Aber's study utilized the Widowhood Questionnaire, and this researcher utilized the Revised Grief Experience Inventory. The setting for Aber's study was the northeastern United States, and the setting for this researcher was the southeastern United States.

Another study on grief experiences of bereaved spouses was conducted by Meuser, Davies, and Marwit (1995). This research examined the degree to which older widow(er)s experienced emotional distress and whether restraint was predictive of grief intensity. Further, the researchers sought to determine risk factor relationships of older widow(er)s characteristic propensities for emotional distress and restraint as predictive of past grief expression and present grief symptomatology.

Personality characteristics related to emotional reactance and control were merged into two indices: characteristic distress and restraint. Characteristic distress was composed of cognitive/behavioral items assessing anxiety, depression, self-esteem, and well-being. Restraint was composed of items that reflect impulse control, suppression of aggression, consideration for others, and sense of personal responsibility. The purpose of this study was to determine if personality style was a risk factor for complicated grief reactions.

The design was a correlational study. The convenience sample (N = 51) was obtained from a large metropolitan area bereavement support groups and through newspaper ads and flyers. The participants consisted of 17 white widowers and 34 white widows. Data were gathered using a questionnaire completed at home. The participants were asked to complete demographic and spousal information, the Texas Revised Inventory of Grief, the Weinberger Adjustment Inventory, and questions about issues related to grief. Also, participants were asked to answer an optional group of open-ended questions regarding grief resolution and reactions to the study.

The Texas Revised Inventory of Grief had 21 behavior/emotion related questions on a Likert scale that measured past and present grief intensity. This measure provided separated scales of past grief (Cronbach's alpha = 0.79 in present sample) and present grief intensity ($\propto$ = 0.92). With regards to validity, the earlier version of the Texas Revised Inventory of Grief, Texas Inventory of Grief, was used in a longitudinal study of older widow(er)s' grief and showed strong correlations to a measure of psychological distress. According to Meuser et al. (1995), the TRIG received the highest rating of nine grief inventories for construct/criterion validity.

The Weinberger Adjustment Inventory had 84 items answered on a Likert scale and measured characteristic distress and restraint. Data from the study were calculated using Cronbach alpha coefficients and were .93 for distress, .82 for restraint, .62 for denial of distress, and .74 for repressive defensiveness. The Weinberger Adjustment Inventory has shown stability correlations of .77 and .71 by females for distress/restraint and .69 and .58 by males for distress/restraint.

Meuser et al. (1995) used hierarchical regression to analyze the data to determine the relative contribution of personality traits in predicting grief outcome. The correlation between past and present grief scores was significant, $r = 0.47$, $p < .01$. A positive relationship was indicated between characteristic distress and grief intensity in both the past, $r = .37$, $p < .01$, and in the present, $r = 0.56$, $p < .01$. However, a significant correlation emerged for restraint and past grief alone, $r = -0.28$, $p < .05$.

Meuser et al. (1995) used four different blocks of predictor variables which were separately entered in the hierarchical regression of the Texas Revised Inventory Grief past and present grief scores. Both past and present Texas Revised Inventory Grief scores were statistically significant ($p < .01$) for cumulative values. Cumulatively, the four blocks predicted a significant amount of the total variance for each score of the Texas Revised Inventory Grief, 48.9% for past and 50.6% for present. Religious affiliation and time since spousal death variables significantly predicted 23% of the total variance for past and 27% for present. Defensiveness

variables added significant values of 25% for past and 10.8% for present.

For the Texas Revised Inventory Grief past, religious affiliation and repressive defensiveness were the only variables to produce a significant Beta weight. Regarding religious affiliation, Protestant had $\beta = -0.30$, $p < .05$ and repressive defensiveness had $\beta = -0.34$, $p < .05$. Significantly less grief intensity was reported by Protestants than Catholics or others. Lower past grief was reported by respondents showing higher repressive defensiveness. Significant Beta weights were found for the Texas Revised Inventory Grief present with religious, $\beta = -0.27$, $p < .05$, and characteristic distress, $\beta = 0.34$, $p < .05$. Respondents reported greater present grief intensity with higher characteristic distress.

The findings of this study suggested to the researchers that widow(er)s may be at risk for complicated grief reactions over time if they have a high characteristic distress. Also, the authors of this study (Meuser et al., 1995) suggested that defensiveness plays a role in how respondents report their past grief experiences. Repressive defensiveness and denial may serve as protection against the emotional intensity of recalled

time of loss reactions. However, their use may not be healthy if it interrupts emotional healing. Meuser et al. (1995) recommended that health care professionals must identify the determining risk factors that widow(er)s face and help them prevent complicated grief reactions.

Meuser et al. (1995) concluded that personality style may be a risk factor for complicated grief reactions. Meuser et al. further concluded that if a widow(er)'s pre-loss personality style remained unchanged by the emotions or events experienced after death of a spouse it would cause complicated grief reactions. Other than religious affiliation, the only significant predictor of recalled time of loss was repressive defensiveness. Defensiveness could serve as a protective function for older widow(er)s in the intensity of their grief reactions when confronted with reminders of past loss.

The Meuser et al. (1995) study on intensity of grief reactions gave credence to conduction of the current study. Meuser et al.'s study and the current study both used instruments that measured grief experiences. Meuser et al.'s study used two instruments, the Texas Revised Inventory of Grief and the Weinberger Adjustment Inventory, and this study used the Revised Grief

Experience Inventory. Both studies were researched in the United States; however, the Meuser et al. study was conducted in an urban central section and this study was conducted in a rural southeastern section. Meuser et al.'s study included men and women who were older adults, and this researcher's study included women who were younger and older adults. The time frame in Meuser et al. Included participants who had experienced spousal death up to 10 years prior, whereas the current study's time frame included participants who had experienced spousal death up to 4 years prior.

Lowenstein, Landau, and Rosen (1994) analyzed the adjustment of a woman to widowhood as a multivariate construct. The purpose of the study was to determine if adjustment to widowhood was a univariate or a multivariate construct. The researchers used four indicators for adjustment to widowhood, functioning in everyday living, depression level, health status, and life satisfaction.

Lowenstein et al. (1994) focused on loss of a spouse, especially in an untimely and unexpected circumstance as an event that is universally perceived as causing the greatest amount of psychophysiologic response. The dependent variable in the study was adjustment to

widowhood and was measured independently by functioning in everyday living, depression level, health status, and life satisfaction. The independent variables were demographic factors, temporal factors, personality factor, social support, and world of work.

Lowenstein et al. (1994) used a number of conceptual frameworks for this study in an attempt to understand this traumatic life event. These conceptual frameworks included the psychodynamic approach, the illness and disease model, the stress and crisis model, the attachment theory, and cognitive and person construct models. Instead of being competitive, these conceptual frameworks were considered complementary to each other. Lowenstein et al. suggested that, due to the variety of theoretical approaches, adjustment to the loss of a spouse may be a multivariate construct.

Data for this research study were based on a stratified random sample drawn from a larger project. Selection was from a population of Jewish urban widows and excluded war widows, widows whose husbands died as a result of terrorism, and those widows who had remarried. As a convenience, three major cities in Israel and their vicinities were defined as the urban population. This

sample included widows who had lost their spouses at least 6 months, but not more than 6 years, prior to data collection.

A representative random sample, 1,487 widows, was drawn from 20,023 widows from a list of recipients of statutory survivors' pensions of the National Insurance Institute. Of the mailed letters and telephone calls, 246 widows gave written consent to participate in the study. The sample relevant to this research related to all widows of the larger research project and consisted of those who were mothers and those whose age was less than 54 (N = 150). Data were collected between May 1985 and October 1986 by structured interview after the loss of spouse.

Adjustment to widowhood was measured by four different measurements. Functioning in everyday living was measured by 13 items that examined perceived performance of activities. These activities included child care, house maintenance, and care maintenance. Internal consistency of these items (Cronbach's alpha) was .82. Depression level was measured by the Zung Self-Rating Depression Scale with Cronbach's reliability coefficient ($\propto$ = .89). Health status was measured by six items, which included perceived physical and mental health, number of visits to physician

during the past 6 months, number of sick days during the past 6 months, use of tranquilizers during the past month, and use of sleeping pills during the last month. For this sample, Cronbach's reliability coefficient for health status was .70. Satisfaction from life was measured by seven items on a 5-point Likert type scale and reflected one's feelings about life on a continuum, such as useful vs. useless and hopeful vs. hopeless. Cronbach's reliability coefficient for satisfaction from life was .89.

The independent variables were divided into five different groups. The first group, demographic factors, consisted of socioeconomic status, religiosity, number of children, continent of birth, and perception of widow's present standard of living. Socioeconomic status was measured by five items. Pearson correlation coefficients for socioeconomic status were computed with a range from .20 to .49 ($p < .005$). For this sample, Cronbach's reliability coefficient was .65. Religiosity was measured by a self-reported single item. Continent of birth was a dummy coded variable. Perception of a widow's present standard of living was compared to living standard prior to spouse's loss and was measured by a single-item

question. The next group of variables included temporal factors which consisted of time lapse since spouse's death, widow's age at loss of spouse, and prior knowledge about husband's possible death. Time lapse since spouse's death was measured by the number of years since spouse's loss. Widow's age at loss of spouse was measured by the number of years. Prior knowledge about husband's possible death was measured by a single-item question. Next, personality factors were measured by Rotter's scale and examined locus of control. This 20-item questionnaire had a Cronbach's reliability coefficient of .89. The next group, social support variables, was measured on a 5-point Likert scale and examined availability of family network and the size of family network, satisfaction from contact with family members, chances of asking help from family members, and perceived availability of friends. For social support, Cronbach's alpha for this sample was .80. Another source of social support, living with a man in the same household, was measured by a single-item question. The last independent variable was world of work and was measured by a single-item question.

Mean, standard deviation, and Pearson moment correlation were used in addition to stepwise multiple

regression. In order to find out which of the independent variables had the potential of explaining a large part of the variability of the dependent variable, stepwise multiple regression was used in four steps. Temporal factors were entered on the first step, personality factors were entered on the second step, demographic variables were entered on the third step, and social support variables and employment were entered on the fourth step. In bivariate and multivariate analyses directionality of the variables was adjusted so that for all variables 1 = low and adjustment for categorical variables 1 = no. Locus of control was adjusted so that 1 = external. In order to identify the independent variables that most influenced each of the dependent variables, canonical correlation was used.

Lowenstein et al. (1994) found that the sample of widows was characterized by relatively high socioeconomic status, secularity, having three children on an average, belonging to the western culture more than the Muslim culture, and having a relatively low perception of present standard of living in comparison to that prior to the loss of spouse. Average age at loss of spouse was 39.30 years (SD = 7.87). Average time lapse since the loss was 48

months (SD = 23.26). Prior knowledge of possible death of spouse was frequently more nonexistent than existent. The average size of family network of the widows was 5.06 (SD = 2.00) for this sample. Satisfaction from contacts with family members and chances for asking help from family members was above average. Low risk of social isolation was suggested for the mean perceived availability of friends. In this sample, the majority of widows had paid employment and no man living with them in the same household. On the average, internal locus of control was more characteristic than external locus of control of this sample of widows.

In this study, Lowenstein et al. (1994) indicated that functioning in everyday living was found to be significantly associated with widow's present standard of living as compared to that before spousal death, her socioeconomic status, number of children, age at loss of spouse, and locus of control. Socioeconomic status and present standard of living accounted for 50% of the explained total variance of widows' functioning in everyday living, r = .41.

Widow's depression level appeared to be related to five factors: locus of control, number of children,

present standard of living as compared to prior one, perceived availability of friends, and involvement in the world of work. Locus of control became the best predictor of a widow's depression level and accounted for 60% of the total explained variance of widow's depression levels, $r = .47$.

Health status was significantly associated with five factors: widow's age at loss of spouse, her socioeconomic status, present standard of living as compared to prior one, locus of control, and number of children. As related to widow's health, locus of control emerged as the most significant variable and accounted for 45% of the total explained variance of a widow's health status, $r = .41$.

Life satisfaction was predicted by the following factors: widow's age at loss of spouse, her socioeconomic status, present standard of living as compared to prior one, perceived availability of friends, and locus of control. Locus of control contributed 60% of the total explained variance of life satisfaction, $r = .51$. Once again, the importance of locus of control is stressed.

Time lapse since spouse's loss, prior knowledge of spouse's possible loss, religiosity, origin by continent of birth, living with a man in the same household, and a

widow's relationship with her family were variables in multiple regressional analysis that were not found to be associated with any of the four measures of adjustment to widowhood. Several factors appeared to be significantly associated with more than one measure of adjustment to widowhood; for example, age at loss of spouse, locus of control, socioeconomic status, number of children, present standard of living as compared to prior one, and perceived availability of friends.

The findings of Lowenstein et al. (1994) suggested that almost all widows were handling everyday living tasks quite well. Of the four measures of adjustment to widowhood, the scores were highest in functioning in everyday living. The findings also suggested significance in that the younger a widow loses her spouse, the poorer her functioning in everyday living. Present standard of living as compared to prior one was impressive in functioning in everyday living (β = .41). In this sample, the more internal locus of control, the less depression following spousal death. Age at loss of spouse in this sample of widows between the ages of 20 and 54 years was not associated with a widow's tendency to depression. Therefore, the loss of a spouse may never feel timely or

readily acceptable to the survivor. Also, the findings suggest that as a widow's age at loss of spouse increased, her health status decreased. The majority of the widows were characterized by fair life satisfaction. However, as a widow's age at loss of spouse increased, life satisfaction decreased. Older widows faced not only widowhood but menopause, empty nest, and the need to care for their parents (Lowenstein et al., 1994).

Lowenstein et al. (1994) concluded that locus of control strongly associated with all four measures of the adjustment to widowhood and emerged as the crucial factor in adjustment to widowhood. Also, the only other variable that is associated with all four of these variables was present standard of living as compared to prior one. The fact that the dependent variables were not associated with the same cluster of independent variables reinforced that the adjustment to widowhood was a multivariate construct.

The best predictor of adjustment to widowhood, locus of control, had subjective and objective dimensions. The subjective dimensions of a widow's perception of health status, depression level, and life satisfaction were significant and strongly associated with the widow's locus of control. However, the objective dimension of

functioning in everyday living was more dependent on environmental resources. Locus of control as a subjective dimension in the adjustment to widowhood supported the cognitive and personal construct models to bereavement.

Lowenstein et al. (1994) recommended that future research be more specific as to which adjustment to widowhood measure is being considered: functioning in everyday living, depression level, health status, or life satisfaction. Lowenstein et al.'s research is germane to this researcher's endeavor because it looks at a woman's adjustment to loss of a spouse. Lowenstein et al.'s research supports adjustment to widowhood as being a multivariate construct.

In another study on widowhood, grief experiences of older women whose husbands had hospice care were examined. Jacobs (1996) indicated that grief was a universal phenomenon that affects every age and every culture. The purpose of the study was to discover and describe older widows' grief experienced during the first 16 months of bereavement. The aúthor stated that there were few studies which focused on grief of older widows and none which focused on the grief of older women whose husbands received hospice care. The major focus was to determine

how older widows of men who received hospice care describe their grief process following the death of their husbands.

Jacobs (1996) defined grief "as a normal, dynamic, unique, multidimensional response to a perceived loss" (p. 281). Bereavement was defined as "the state of having suffered a loss" (Jacobs, 1996, p. 281). Grief and bereavement are often used interchangeably in the literature pertaining to loss by death. Hospice provides bereavement care to loved ones for one year after the death of the patient and was defined as a palliative program of care for persons with a terminal illness and their families.

The Jacobs study was qualitative in design, utilizing grounded theory. The sample (N = 6) consisted of older widows whose husbands were enrolled in a hospice program in a southern metropolitan setting in the United States. The semi-structured interview sessions were conducted in the widows' homes during the following time frames of bereavement: 1 to 4 months, 7 to 10 months, and 13 to 16 months. A total of 20 interviews were conducted with each interview lasting approximately 1½ hours. Each widow was initially asked to tell their experience in dealing with the loss of their husband.

Jacobs (1996) obtained a list of widows who met the criteria from a hospice program in the southeastern United States. Initially, each widow was contacted by telephone. The nature of the study was explained, and their anonymity was assured. Next, the visits to the home were scheduled, and a written explanation was given to each widow. All respondents signed a written consent form.

Purposeful or theoretical sampling was used in this study. All widows were over the age of 60 years, and their husbands had received hospice care during their illness. The time of bereavement for the widows ranged from 1½ to 4 months when the study began. The range of age for the widows was 66 to 78 years with a mean of 74.3 years. The average years of marriage for the widows was 48.3 years. Of the 6 widows, 4 were Caucasian and 2 were African-American. The widows were interviewed again at 7 to 10 months of bereavement, and finally interviewed at 13 to 16 months.

Data analysis was completed by transcribing the interviews, categorizing key statements, developing a definition of grief, and conceptualizing a grounded theory of the grief experience of older women whose spouses received hospice care. The audiotaped interviews were

typed by a transcriptionist into Oracle, which is a text-oriented database management computer program. Oracle was used to facilitate the creation, storage, coding, analysis, and retrieval of data. From the three phases of data, cross comparisons of findings were made and compared to the literature.

The investigator who had prolonged engagement with the data and persistent observation determined credibility. Two nurse experts in grief and grounded theory determined its acceptability. The study was determined to be internally coherent by the experts after examining the data, findings, interpretations, and recommendations. The audit trail method was used to establish confirmability.

Jacobs' (1996) findings included five major concepts from 28 grief categories: being aware, experiencing distress, supporting, coping, and facing new realities. Being aware was defined as acknowledgment of the illness, limited prognosis, impending death or death itself, and grief after the death. Being aware developed as a result of combining three grief categories, being openly aware, not being openly aware, and intuiting.

The second major concept identified by Jacobs (1996) was experiencing distress. Experiencing distress was defined as turmoil experienced during the illness and following the death. This concept was developed from physical, emotional, spiritual, social, and financial distress. Loneliness was the major cause of emotional distress in phase 3 at 13 to 16 months after the death of their husband. Clothing of the deceased was the strongest attachment that created emotional distress.

The third identified concept was "supporting" according to Jacobs (1996). Supporting was defined as assistance of words, actions, relationships, or resources in the process. Supporting emerged from caring for spouse, supporting others, seeking support, receiving support, and neglecting self.

Jacobs (1996) named the fourth concept as coping. Coping was a strategy used by the widows to alleviate the distress of grief. Coping could be a cognitive, behavioral, or psychosocial strategy. Remembering, protecting, keeping busy, caring for self, and rationalizing were categories that made up the core concept of coping.

The last concept identified by Jacobs (1996) was facing new realities. The widows began to face reality when they were made aware of the terminal diagnosis, but it was not until the actual death that grieving began for these individuals. The widows sought and received support and engaged in coping strategies in order to relieve the distress of the death of their spouse. Jacobs found that the effectiveness of the support received and coping strategies used were directly related to the acceptance of the reality of death and the widow's adjustment to her loss and a new identity. Data revealed that as the grief process occurred, reality increased. Thus, the widow accepted her new lifestyle and began to adapt.

There were three time frames of bereavement examined by Jacobs (1996). These were phase 1 (1 to 4 months), phase 2 (7 to 10 months), and phase 3 (13 to 16 months). The first phase of data collection found the widows physically and emotionally exhausted due to providing care for their spouse over a long period of time. Also, acute emotional distress was experienced during this phase. The most common emotional reaction during this time was crying. All of the widows spent a great deal of time remembering the pain and suffering experienced by their

spouse. Guilt and anger were also expressed during this phase. Loneliness and emptiness emerged due to lack of support from spouse. During the first 4 months, the widows were just beginning to reorganize their lives.

According to Jacobs (1996), phase 2 (7 to 10 months) of data collection showed disrupted sleep patterns of the widows. Some experienced depression and isolation due to physical limitations that prevented them from social activity. This phase was still characterized by emotional turmoil, but was less severe. Loneliness continued to be a problem as family and friends had lives of their own.

Two important coping strategies, keeping busy and remembering, emerged in phase 2. All widows reported that keeping busy out of the house was an important coping strategy. However, returning home was difficult due to the reality of the loss. Frequently, remembering was used as a coping strategy. In remembering, the widows recalled positive and negative aspects of the spouse and their relationship. Painful images of the illness were not recalled as often but were just as vivid as in phase 1.

Jacobs (1996) identified phase 3 as the widow's silently grieving due to family members avoiding acknowledgment of death and the grief process of the

widow. Although friends were more supportive than family, the widows felt as though they were not receiving adequate support. Remembering as a coping strategy continued and became more positive. Within this phase, painful images of the illness had begun to fade but still could be recalled.

Jacobs (1996) concluded that grief was a normal, multidimensional process characterized by distress. Relief was sought through coping strategies and enabled the widows to face new realities. Each new reality caused them distress. As the widow effectively coped, their ability to face new realities was directly related. Therefore, as the widow successfully coped with the distress of each new reality, the widow became stronger and was able to face another new reality.

The study by Jacobs (1996) suggested an aggressive approach be taken to ease the pain and provide comfort to women who suffer the death of a spouse. Approaches included interventions during the husband's illness, such as exercising, eating balanced meals, and having regular health checkups. Programs on health maintenance for caregivers, respite care, and support groups must be accessible to meet the needs of older adults who care for terminally ill spouses. Therefore, this was vital to

health maintenance and quality of life for women according to the researcher.

Jacobs (1996) had several recommendations based on this study. One recommendation was to use a longitudinal design to determine if there is a difference in anticipatory grief and grief experienced after the loss. Jacobs also suggested that a comparison of grief experiences of older widows whose husbands received hospice care with that of older widows whose husbands did not receive hospice care. The effect of forewarning on adjustment to loss was another recommended topic of research that would be beneficial. Last, gender and cultural differences need to be researched. Jacobs (1996) concluded that more research on the grief process would increase knowledge.

Jacobs' (1996) study on a comparison of grief reactions at different time frames lends credence to the current study under investigation. Both Jacobs (1996) and this researcher investigated widows who had lost a spouse in a southern setting. However, Jacobs' study was conducted in a metropolitan setting and this researcher's study was conducted in a rural setting. Jacobs conducted interviews of older widows whose husbands had received

hospice care before death and during the time frames of 1 to 4 months, 7 to 10 months, and 14 to 16 months. This researcher used the Revised Grief Experience Inventory in widows age 21 years and older and compared the time frames of 6 months to 2 years after spousal death and over 2 years to 4 years after spousal death.

A research study conducted by Porter (1994) examined older widows' experience of living alone at home. In this phenomenological study, a nonprobability, purposeful sampling was used. The seven women who met inclusion criteria were obtained by posting notices at senior citizens' centers and publishing notices in church newsletters. Porter (1994) found the ages of the widows ranged from 75 to 83 years. All women had been widowed at least 1 year with the range from 15 months to 42 years. The widows lived alone in their homes that had been shared with their deceased spouse. Although some of the women were physically impaired, all reported that they were healthy. Each widow had at least one child living within 30 miles.

Data were gathered using an instrument based on one open-ended statement: "As a person who lives alone, please describe how you do this" (Porter, 1994, p. 20). There

were approximately 20 relevant probes included in the interview. Content validity was approved as satisfactory by two community health nurses with extensive experience in working with older widows, an older widow who was not a participant in the study, and 5 doctorally prepared researchers. Also, a pilot study was conducted during interviews with the first participant with no changes needed.

Porter (1994) visited each volunteer at the widow's home to determine the widow's ability to be a good informant and to obtain informed consent. The first interview was initiated, and each interview lasted approximately 2 hours. Nondirective techniques were used to pursue more information. All interviews were tape-recorded, and the researcher incorporated personal observations of the widow's behaviors and their homes into the transcript. A total of 21 interviews with 7 women were conducted. Data were deemed reliable due to each widow expressing similar ideas during the interviews. Also, data validity was enhanced because all interviews were conducted in the widows' homes.

General methodological steps were used in data analysis. These steps included bracketing knowledge,

analyzing data, talking with others, and filling out phenomena of the lived experience. Data sets from two transcripts that included examples of all component phenomena were prepared for evaluating the reliability/consistency of data analysis. A doctorally-prepared phenomenological researcher compared the two data sets, found no discrepancies, and concluded the data analysis as reliable. To validate the analysis, the researcher participated in dialogue with participants and nurse researchers. The last interview was used to validate analysis from previous interviews with each participant. Also, the component phenomena were discussed with 8 qualified judges, which included an older widow who did not participate, and 6 doctorally-prepared researchers, and the data were considered valid.

Porter (1994) developed four phenomena with regard to older widows' experience of living at home alone. Phenomena that emerged during the course of the investigation were as follows: making aloneness acceptable, going my own way, reducing my risks, and sustaining myself.

Porter (1994) concluded that making aloneness acceptable was gradually done by the widows. The widows

counted on others to share their lives. Ways to spend time with companions other than husband were found. Also, familiar routines were changed to establish new routines.

The next experience of living at home alone, according to Porter (1994), was "going my own way." The widows fulfilled their basic responsibilities to living alone. The widows performed the tasks that had to be done by themselves or with help. Financial priorities and financial routines were established.

Another experience of living home alone was reducing risks according to Peter (1994). They were concerned with safety in everyday tasks. Some of the risks included losing one's balance, falling, and doing too much. However, the widows accepted assistance when needed. All the widows believed that they were taking risks when doing certain activities outside the home and going out in certain situations.

The last experience of living home alone identified by Porter (1994) was sustaining self. The widows did what was necessary to continue living at home. The widows tried to take care of themselves by staying active, eating a well-balanced diet, and staying in touch with current events. Also, the widows took care of their property and

business affairs. The women compared themselves with other older people who had not taken care of themselves. Satisfaction was found in doing for others and for themselves. All the widows hoped for a future of living alone.

Porter (1994) concluded that the phenomenon of living at home alone was considered significant to older widows' experiences. The information drawn from seven widows could not be considered valid characterization of all older widows. Therefore, it was recommended that phenomenological researchers explore and compare the experiences of other groups of women. Further data could be analyzed to identify older widows who were at risk for problems with the identified phenomenon of this research. Thus, widows could be offered interventions for living alone.

Both Porter (1994) and this researcher examined widows after spousal death. Porter investigated older widows' experience of living alone at home while this researcher investigated differences in grief experiences of women who lost their spouse over varying periods of time. Porter's sample came from a city of 50,000 persons, and this researcher's sample came from a county of 20,000

persons. The age group for Porter's study included widows from 75 to 83 years who had been widowed at least one year, and the age group for this researcher included widows over 21 years who had been widowed at least 6 months. Interviews were used by Porter while an inventory was used by this researcher.

Conclusion

A review of the literature revealed several studies on grief experiences relevant to the current research study. In the review of literature, one study (Hyrkas et al., 1997) was identified which compared the difference in the intensity of grief before or after 2 years of the experienced bereavement of women and men. The second research study (Aber, 1992) examined the paid work role as a critical factor and determinant of health risk of older widows during their conjugal bereavement. Meuser et al. (1995) examined the degree to which older widow(er)s experience emotional distress and whether restraint is predictive of grief intensity. Lowenstein et al. (1994) analyzed the adjustment of a woman to widowhood as a univariate or a multivariate construct. Jacobs (1996) focused on grief of older widows whose husbands received

hospice care. Porter (1994) studied older widows' experience of living home alone.

All of the research studies identified in the review of literature were similar to the current research in that all the studies focused on widowhood. The research by Hyrkas et al. (1997) concluded that there were significant differences in the intensity of grief when comparing less than 2 years or more than 2 years since spousal death. Aber (1992) concluded a history of paid work during a woman's married years may serve as a health protection after she has become widowed. Meuser et al. (1995) concluded that personality style may be a risk factor for complicated grief reactions. Lowenstein et al. (1994) found that locus of control strongly associated with four measures of the adjustment to widowhood and emerged as the crucial factor in adjustment to widowhood. Jacobs (1996) researched 28 grief categories that included five major concepts of being aware, experiencing distress, supporting, coping, and facing new realities. In the study by Porter (1994), four phenomena emerged that included making aloneness acceptable, going my own way, reducing my risks, and sustaining myself. All of the studies reviewed

recommended that further research related to widowhood be conducted.

Chapter III

The Method

This study attempted to identify four possible consequences of grief in widows which included depression, physical distress, existential tension, and tension and guilt. The study also attempted to determine if there were differences of intensity between these consequences of grief in widowed women as time passed since the death of a spouse. Specifically, the purpose of this study was to examine the differences in grief experienced by women who lost a spouse from a time period of 6 months to 2 years and over 2 years to 4 years prior to the study.

Design of the Study

The research design for this study was descriptive. A descriptive study is one in which the main objective is to accurately portray the characteristics of individuals or groups and the frequency with which certain phenomena occur (Polit & Hungler, 1995). This design was deemed appropriate since the researcher identified limited

research available on the subject of grief reactions of women during spousal bereavement, which was the phenomenon of interest for this study.

Variables

Variables of interest were grief experiences of women after spousal death as measured by the Revised Grief Experience Inventory (RGEI). Spousal death was the control variable. The mediating variables may have included the grief experiences of the women, participants' willingness to return the inventory, and the truthfulness of participants in answering the inventory.

Limitations

In this research there were limitations encountered with the setting, the population, the collection of data, and the RGEI. The convenience sample chosen may not have adequately represented the characteristics of the population of widowed women. The small sample size and the use of one setting limited generalization of the findings to other populations and settings. Mailed questionnaires such as those utilized in this study are frequently used in collection of data, but response rates are often low and are considered to be a limitation to the study. Also,

the instrument used was not designed to compare grief of widowed women.

Setting, Population, and Sample

The setting for the research sample was a selected county in a rural southeastern state. The population consisted of female surviving spouses who were over the age of 21 years. The sample was identified by reviewing death certificates from the years 1993 to 1997. The respondents had experienced grief for more than 6 months prior to completing the inventory as this was chosen as a conservative estimate of an acute grieving time frame. The participants were divided into two subgroups which consisted of bereaved individuals in a time frame from 6 months to 2 years and over 2 years to 4 years after the death of their spouse. The convenience sample consisted of clients in the selected county in a rural southeastern state who met the criteria and were willing to participate in the study.

Methods of Data Collection

Instrumentation. The Grief Experience Inventory (GEI) was used to measure the grief experience for individuals who experienced a loss. The GEI has been used to compare

survivors of significant others being cared for by hospice versus hospital settings and after the death of a significant other due to cancer with no significant differences found. The GEI was a 135-item measure of grief scored on a dichotomous (yes/no) measure. The instrument was revised due to longer forms being impractical. The shortened version of the GEI, developed by Lev, Munro, and McCorkle (1993), is called the Revised Grief Experience Inventory (see Appendix A). The final version consisted of 22 items from the original 135-dichotomous item GEI with corrected item-total correlations above 0.35. Responses to the 22-item revised instrument were increased by changing the scoring from the dichotomous scoring to a 6-point scale. The RGEI consisted of 22 questions on a Likert scale from 1 to 6: 1 (strong agreement), 2 (moderate agreement), 3 (slight agreement), 4 (slight disagreement), 5 (moderate disagreement), and 6 (strong disagreement).

Subscales of the RGEI included depression, physical distress, existential tension, and tension and guilt. Depression was the first subscale. The RGEI had 6 of the 22 items that related to depression. Depression was referred to in numbers 7, 8, 9, 13, 16, and 17 on the RGEI. Statements that represented depression included, "I

feel extremely anxious and unsettled" and "I frequently feel depressed."

The second subscale was physical distress. There were 7 items out of the 22 that related to physical distress. Items referring to physical distress were numbers 3, 6, 10, 12, 18, 19, and 22 on the RGEI. Physical distress was identified with statements such as "My arms and legs feel very heavy" and "I am not feeling very healthy."

Existential tension was the third subscale. This subscale consisted of six items out of the 22 statements. Existential tension was referred to in numbers 5, 11, 14, 15, 20, and 21 on the RGEI. Existential tension was depicted by items such as "I feel lost and helpless" and "Life seems empty and barren."

The final subscale was tension and guilt. Tension and guilt was referred to in numbers 1, 2, and 4 on the RGEI. Tension and guilt was represented by statements including "I frequently experience angry feelings" and "I have feelings of guilt because I was spared and the deceased was taken."

Responses to each of the 22 items on the RGEI were rated on a 6-point scale which ranged from strong to slight agreement and from slight to strong disagreement.

Scoring to the subjects' responses on each statement was recorded as follows: 1 (strong agreement) = 6, 2 (moderate agreement) = 5, 3 (slight agreement) = 4, 4 (slight disagreement) = 3, 5 (moderate disagreement) = 2, and 6 (strong disagreement) = 1. The score was achieved by summing the scales so the higher the score, the more grief experienced. The range of possible scores was 22 to 132. The lowest score of 22 signified less grief was experienced, and the highest score of 132 signified more grief was experienced.

Lev et al. (1993) established content validity by a group of experts, who were doctorally-prepared nurses with expertise in oncology nursing, and clinical specialists in two hospice settings. The reliability of the subscales was as follows: depression, 6 items ($\propto$ = 0.80); physical distress, 7 items ($\propto$ = 0.83); existential concerns, 6 items ($\propto$ = 0.87); and tension and guilt, 3 items ($\propto$ = 0.72). The internal consistency reliability (coefficient alpha) was 0.93 for the RGEI.

The Shelton Demographic Survey, a 10-item researcher-designed tool, also was used to gather data (see Appendix B). The purpose of the Shelton Demographic Survey was to obtain information from the participants such as age,

religion, involvement of religious practices, support systems, recent illnesses, other losses, and present or past paid work role. Also, the Shelton Demographic Survey asked participants an open-ended question in which respondents were asked to share anything that might help someone else who had lost a spouse.

Procedures

In order to obtain permission to use the RGEI, the researcher initially contacted Dr. Susan Jacobs who had previously used the instrument. It was learned that the RGEI was of public domain. Therefore, permission to use the instrument was not needed. An application for acceptance of the proposed study was submitted and approved by the Committee on the Use of Human Subjects in Experimentation at Mississippi University for Women (see Appendix C).

Potential subjects, widows aged 21 years and older, were identified from death certificates in the selected county of the rural southeastern state. Death certificates are considered public record. Consequently, permission was not needed to obtain a list of potential subjects for the research study. Thus, names and addresses of potential subjects who met the criteria were obtained from death

certificates. All individuals who were eligible on the list were sent a packet. The researcher prepared and mailed packets that consisted of the RGEI, the Shelton Demographic Survey, the informed consent introductory letter, and a self-addressed, stamped envelope to each potential subject. The purpose of the study was explained to each potential subject in the informed consent introductory letter.

The letter of consent stated that there were no identified risks in participating in the study and informed the subject that confidentiality would be maintained. The participants were asked to sign the informed consent introductory letter which indicated their permission to participate in the study (see Appendix D). If consenting to participate in the study, the subjects were asked to complete the Shelton Demographic Survey and the RGEI. The subjects were then asked to return the packets to the researcher in the self-addressed, stamped envelope. Follow-up remainder postcards were mailed to the sample 2 weeks later (see Appendix E). Data collection occurred in April and May of 1998.

Methods of Data Analysis

Descriptive statistics were used to analyze the data obtained from the Demographic Survey and the RGEI. Specifically, measures of central tendency which included mean and standard deviation were used to analyze the data. Also, data were analyzed using a two-tailed *t* test to compare the two subgroups of participants of 6 months to 2 years and over 2 years to 4 years after the death of their spouse. Content analysis was used to explore themes in the open-ended question on the demographic survey.

Conclusion

Chapter III described the methodology of this study. The design of the study, setting, population, and sample were described. Methods of data collection which included instrumentation, procedure, and data analysis were summarized.

Chapter IV

The Findings

The purpose of this study was to compare the differences in grief experiences of widowed women based on length of bereavement. A descriptive design was utilized. The Revised Grief Experience Inventory (RGEI) was utilized to measure the grief experiences of widows who experienced the loss of their spouse and who participated in the study. Data were analyzed using measures of central tendency, which included mean, standard deviation, a two-tailed t test to compare the groups, and content analysis to explore themes of an open-ended question. The findings from the study are presented in this chapter.

Description of the Sample

The sample consisted of widowed women living in a northeast rural county of Mississippi who completed and returned the RGEI and the demographic survey. The total number of questionnaires mailed to the widowed women was 131. Of the 131 questionnaires mailed, 19 of the

questionnaires were returned undelivered due to forwarding order expired, moved, and left no address, no forward order on file, no mail receptacle, or deceased. A total of 22 individuals returned the questionnaires. However, two of the questionnaires were returned without consent form signed and unanswered and, therefore, were eliminated from the study. Of the two that were eliminated from the study, an explanation was included with the returned questionnaires. One widow was unable to answer the questions due to Alzheimer's disease, and one widow was unwilling to answer the questions due to her happy remarriage. This resulted in a final sample of 20 widowed women for the study. The breakdown of the respondents (N = 20) represented 17.9% of the widowed women surveyed. The first group of respondents consisted of 10 widows (50% of the sample) who had experienced the loss of a spouse 6 months to 2 years prior to the study, and the second group of respondents consisted of 10 widows (50% of the ample) who had experienced the loss of a spouse over a time period of 2 years to 4 years prior to the study. The ages of the participants ranged from 32 years to 86 years (M = 62.5) with two subjects not responding to the question

concerning age. The age distribution of the sample is depicted in Table 1.

Table 1

Age Distribution of the Sample by Frequency and Percentage

Age (years)	f	%
30-39	2	11.1
40-49	1	5.6
50-59	4	22.2
60-69	6	33.3
70-79	3	16.7
80-89	2	11.1

Note. n = 18.

The current marital status, ethnic distribution, religious affiliation, and religious service attendance of the respondents also were examined. The majority (n = 19, 95%) of the respondents were currently widowed, and all (100%) were Caucasian. Nineteen (95%) of the sample expressed Protestant as their religious affiliation. Additionally, 16 of the widows (80%) attended religious services at least once a week. The demographics related to

current marital status, ethnicity, religious affiliation, and religious service attendance are presented in Table 2.

Table 2

Demographics of Current Marital Status, Ethnicity, Religious Affiliation, and Religious Service Attendance by Frequency and Percentage

Variable	f	%
Current marital status		
Married	0	0.0
Widowed	19	95.0
Divorced	0	0.0
No response	1	5.0
Ethnicity		
Caucasian or White	20	100.0
African American or Black	0	0.0
Native American or Alaskan Native	0	0.0
Asian or Pacific Islander	0	0.0
Religious affiliation		
Protestant	19	95.0
Catholic	0	0.0
Jewish	0	0.0
None	0	0.0
Other--Pentecostal	1	5.0
Religious service attendance		
2 times a week	11	55.0
1 time a week	5	25.0
2 times a month	1	5.0
1 time a month	0	0.0
4 times a year	2	10.0
Other	1	5.0

Note. n = 20.

When responding to whether there was a close friend/family member with whom to discuss feelings, 90% of the 20 individuals who completed the survey indicated yes and 10% indicated no. Sixteen (80%) of the responding widowed women indicated that they had held a paid job while married, and 4 (20%) women responded they had never held a paid job during marriage.

Additionally, participants were surveyed regarding diagnosis of any recent illness within a certain time frame. Four (30.76%) of the women responding to this question indicated they had been diagnosed with an illness within the last 6 months. Demographics of diagnosis with any illness based on time frame are presented in Table 3.

Table 3

Demographics of Diagnosis with any Illness Based on Time Frame by Frequency and Percentage[a]

Time frame	f	%
Less than 6 months ago	4	30.76
7 months to 1 year ago	0	0.00
13 months to 18 months ago	2	15.38

(table continues)

TABLE 3. (continued)

Time frame	f	%
19 months to 2 years ago	2	15.38
Over 2 years to 3 years ago	4	30.76
Over 3 years to 4 years ago	2	15.38

Note. n = 13.

[a]Respondents were told to select as many time frames as applied.

Subjects were also asked to select any experienced changes in their life since widowhood. The most frequently cited change was a decrease in finances. Demographics of changes since widowhood are presented in Table 4.

Table 4

Demographics of Changes Since Widowhood in Rank Order by Frequency and Percentage[a]

Time frame	f	%
Decrease in finances	13	76.47
Death of a close friend or family member	5	29.41

(table continues)

TABLE 4 (Continued)

Time frame	f	%
Loss or gain of a job	2	11.76
Moved from where you lived	2	11.76
Other--Adjust to being alone	1	5.88

Note. n = 17.

[a]Respondents were told to select as many time frames as applied.

The Shelton Demographic Survey also provided a space for the participants to write anything that the widows would like to share that might help someone else who had lost a spouse. Seventeen participants wrote responses in this section. Content analysis was used to ascertain common themes among the responses. Two common themes were identified: spirituality and lapse of time.

Spirituality. The first theme that was identified in the write-in responses was spirituality. A total of 13 widowed women wrote responses with a spiritual theme. The following are examples of responses which reflected the theme of spirituality:

> Only by the grace of God have I been able to go on living.

. . .

Seek comfort from the Lord and depend on Him.

. . .

Stay close to God and pray.

. . .

I strongly rely on my Christian faith.

. . .

Daily talking with the Lord, studying His word has helped me understand that death is part of living.

. . .

God is the only thing that will ease the pain of losing the one you love.

. . .

I know that death is not the end but only the beginning of Eternity.

Lapse of time. Lapse of time was the second theme identified. Three of the participants wrote responses reflecting the lapse of time theme. The following responses reflect lapse of time:

Do not make any decisions too quickly.

. . .

Do not make any major decisions for 18 months after a death.

. . .

Time will soften the blow. Remember time heals all wounds.

One individual replied with a response that did not fit with the other themes. The write-in response that did not fit was as follows:

I have had 27 major operations.

Results of the Data Analysis

Data were analyzed in order to answer the following research question: Is there a difference in grief experiences by women who lost their spouse over varying periods of times? The RGEI was utilized to measure the grief experiences of the participants. There were 22 items which were presented in a Likert scale with 1 indicating strong agreement and 6 denoting strong disagreement. Items were recoded for scoring purposes. The possible scores for the RGEI could range from 22 to 132. The scores from the 20 participants ranged from 22 to 132. In order to determine if there was a difference in grief experienced over varying periods of time, the women were divided into two groups. These data were analyzed to determine if there was a difference in grief experiences of the widowed women who had been widowed 6 months to 2 years (Group 1) and over 2 years to 4 years (Group 2).

A *t* test was utilized to analyze the difference in mean scores between the groups. The critical value for the .05 level of significance was 2.101 on a two-tailed test. The *t* value was computed to be -.299. Thus, there was no significant difference between the mean RGEI scores of the two groups. Summary of statistics for the RGEI utilized are presented in Table 5.

Table 5

Comparison of RGEI Scores Utilizing a Two-Tailed Dependent *t* Test Analysis

Group	n	M	SD	t
1	10	3.195	1.95	-.299
2	10	3.436	1.63	

Note. Group 1 = Widowed 6 months to 2 years. Group 2 = Widowed over 2 years to 4 years.

Additional Findings

The REGI was divided into four subscales that measured depression, physical distress, existential tension, and tension and guilt. Summary statistics and a *t* test were utilized for each factor.

Depression was the first subscale. The RGEI had 6 of the 22 items that related to depression. Depression was referred to in numbers 7, 8, 9, 13, 16, and 17 on the RGEI. Statements that represented depression included, "I feel extremely anxious and unsettled" and "I frequently feel depressed."

A *t* test was utilized to determine if there was a significant statistical difference between the groups for the first factor of depression. The critical value for the .05 level of significance was 1.982 on a two-tailed test. The *t* value was computed to be .428. Thus, there was no significant difference between the mean scores on the depression subscale of the two groups. Summary statistics for depression can be examined in Table 6.

Table 6

Comparison of Depression Scores Utilizing a Two-Tailed Dependent t-Test Analysis

Group	n	M	SD	t
1	60	2.917	2.181	.428
2	60	2.750	2.088	

Note. Group 1 = Widowed 6 months to 2 years. Group 2 = Widowed over 2 years to 4 years.

The second subscale was physical distress. There were 7 items out of the 22 that related to physical distress. Items referring to physical distress were numbers 3, 6, 10, 12, 18, 19, and 22 on the RGEI. Physical distress was identified with statements such as "My arms and legs feel very heavy" and "I am not feeling very healthy."

A *t* test was utilized for statistical significance for physical distress between the groups. The critical value for the .05 level of significance was 1.980 on a two-tailed test. The *t* value was computed to be -.888. Therefore, there was no significant difference between the mean scores of the two groups on the physical distress subscale. Summary statistics for physical distress is depicted in Table 7.

Table 7

Comparison of Physical Distress Scores Utilizing a Two-Tailed Dependent t-Test Analysis

Group	n	M	SD	t
1	70	3.314	2.204	-.888
2	70	3.657	2.365	

Note. Group 1 = Widowed 6 months to 2 years. Group 2 = Widowed over 2 years to 4 years.

Existential tension was a third subscale. This subscale consisted of 6 items out of the 22 statements. Existential tension was referred to in numbers 5, 11, 14, 15, 20, and 21 on the RGEI. Existential tension was depicted by items such as "I feel lost and helpless" and "Life seems empty and barren."

A *t* test was performed to determine statistical significance for existential tension. The critical value for the .05 level of significance was 1.982 on a two-tailed test. The *t* value was computed to be -1.255. Consequently, there was no significant difference between the mean scores of the two groups on the existential tension subscale. Summary statistics for existential tension are presented in Table 8.

Table 8

Comparison of Existential Tension Scores Utilizing a Two-Tailed Dependent t-Test Analysis

Group	n	M	SD	t
1	60	3.167	2.203	
				-1.255
2	60	3.667	2.160	

Note. Group 1 = Widowed 6 months to 2 years. Group 2 = Widowed over 2 years to 4 years.

The final subscale was tension and guilt. There were three items that referred to tension and guilt. Tension and guilt referred to numbers 1, 2, and 4 on the RGEI. Tension and guilt was represented by statements including "I frequently experience angry feelings" and "I have feelings of guilt because I was spared and the deceased was taken."

A *t* test was performed to determine statistical significance for tension and guilt. The critical value for the .05 level of significance was 2.004 on a two-tailed test. The *t* value was computed to be -.531. Therefore, there was no significant difference between the mean scores of the two groups on the tension and guilt subscale. Summary statistics for tension and guilt are depicted in Table 9.

Table 9

Comparison of Tension and Guilt Scores Utilizing a Two-Tailed Dependent t-Test Analysis

Group	n	M	SD	t
1	30	3.533	2.240	-.299
2	30	3.833	2.135	

Note. Group 1 = Widowed 6 months to 2 years. Group 2 = Widowed over 2 years to 4 years.

Summary

This chapter presented a description of the sample. This chapter also presented the results of data analysis using descriptive statistics and content analysis. Results of the data collection were described in narrative and table format. The following chapter contains a summary and discussion of the data described in this chapter.

Chapter V

The Outcomes

The purpose of this descriptive study was to compare the differences in grief experiences of widowed women based on length of bereavement. The Neuman Systems Model was the theoretical framework for this study. This chapter presents a discussion of the findings in relation to the research question. Also, included in this chapter are conclusions, implications for nursing, and recommendations derived from the study.

The research question for this study was as follows: Is there a difference in grief experiences by women who lost their spouse over varying periods of time? The sample consisted of 20 widowed women from a rural county in Northeast Mississippi who had been widowed at least 6 months to 2 years and over 2 years to 4 years and who completed the demographic survey and the Revised Grief Experience Inventory (RGEI).

Descriptive data were collected utilizing the demographic survey. Descriptive statistics were used to

analyze the demographic characteristics of the participants answering the research question. Also, content analysis was used to explore common themes in an open-ended question. The RGEI was utilized to determine the grief experiences of the widowed women.

Summary of Findings

The sample (N = 20) included 10 widowed women who lost their spouse 6 months to 2 years prior to the study and 10 widowed women who lost their spouse over 2 years to 4 years prior to the study. The ages ranged from 32 years to 86 years with a mean age of 62.5 years. The majority of the individuals were not currently married (n = 19, 95%). All of the individuals were Caucasian or white (n = 20, 100%), and the majority of the individuals were Protestant (n = 19, 95%). All 20 of the respondents reported religious service attendance. Also, the majority of the individuals reported religious service attendance at least two times a week (n = 11, 55%). Thirteen (65%) of the participants reported diagnosis with an illness within 6 months to 4 years ago. Changes since widowhood were reported by 17 participants (85%) with the most frequently cited changes being a decrease in finances.

The open-ended question on the demographic survey, which asked if there was any additional information that the widows would like to share, identified two common themes. The two themes that emerged were spirituality and lapse of time. Of the participants, 13 write-in responses indicated a sense of spirituality, while three indicated a lapse of time.

The findings indicated that grief experiences of widowed women were similar regardless of length of bereavement. The mean scores on the RGEI were 3.195 (*SD* = 1.95) for Group 1 widows who had been widowed for 6 months to 2 years and were 3,436 (*SD* = 1.63) for Group 2 widows who had been widowed for over 2 years to 4 years. There was no significant difference between the mean RGEI scores of the two groups.

Additional findings compared the mean scores of the subscales on the RGEI and compared the groups utilizing a *t* test to determine any significant differences. All four subscales indicated that both groups of widows had similar grief experiences as there was no significant difference between the mean scores of any of the four subscales of the two groups.

Discussion

In this study there was no significant difference in grief experiences of widow women based on length of bereavement. This may have been due to the small number of respondents. It may also have been due to the homogeneous sample in that all participants were Caucasian, 95% were Protestant, and were currently unmarried at the time of the survey. Perhaps the differences in the time span for the length of grieving were not long enough to show a difference in grief response. Additionally, the instrument utilized to determine grief responses had only been previously used with urban widowed men and women; therefore, the RGEI may not have been reliable with a group of rural women.

Another possible reason for there being no difference in grief experiences of widowed women based on length of bereavement might have been paid work role. Aber (1992) indicated that paid work role has a positive impact for women's health during bereavement. The findings from this study also indicated that paid employment may have a positive impact for women's health during bereavement as the majority of widows in this study had a paid work role while married. Only two widows reported a loss or gain of

a job since widowhood. Thus, many of the widows had worked in the past.

Another potential reason for there being no difference in grief experiences of widowed women based on length of bereavement could have been the widows having a close friend/family member with whom to discuss feelings. The majority of the widowed women attended religious services at least one time a week. Perhaps, interacting with a number of people on a weekly basis gave them the opportunity to discuss their feelings. Thus, these widows' grief experiences may have been affected by religious service attendance which afforded them a time of interaction with other individuals.

Research has shown that support systems may affect grief experiences. Bowling and Cartwright (1982) reported that most widows obtained emotional, social, and practical support from a network of relatives and friends. In the rural South, traditionally families live close to one another and have close relationships. Therefore, children living close to home would be an important source of support for these widows.

Spirituality was the most common theme that emerged and appeared to be imperative to the widowed women during

bereavement as evidenced by the responses. The findings of this study indicated that the majority of widows had a dependence on spirituality. Most responses in this area were related to God and prayer. The current study was conducted in the Bible Belt of the South where people are reared to turn to prayer and scripture in time of need. This may explain why these widows relied on spirituality as there was no difference in grief experiences of widows in this setting. There were no identified studies in the literature which discussed spirituality. However, Meuser et al. (1995) reported that religious affiliation was a variable that produced significantly less grief intensity by Protestants than Catholics or others. In the current study, 95% of the participants were Protestants. The current study did not examine if Protestants had less grief intensity.

Even though there was no difference in grief experiences of widow women based on length of bereavement, responses to the open-ended question indicated that grief would decrease with time. Lapse of time was the second most common theme identified and was used by three respondents. In the review of literature, a research study by Hyrkas et al. (1997) concluded that the intensity of

grief seems to decrease as the time from spousal death increases. The findings from Hyrkas et al. conflict with the findings in this study which may be due to the different settings in the study and a larger sample. The Hyrkas et al. study was conducted in Finland while the current study was conducted in a rural area.

Additional findings included a comparison of four subscales between the two groups that measured depression, physical distress, existential tension, and tension and guilt. No significant difference in depression, existential tension, or tension and guilt may be related to the widows attending church frequently and having someone to talk with about feelings. These widows were part of an aging family that may have helped to decrease depression, existential tension, and tension and guilt. Also, these widows lived in a rural community that traditionally keeps close ties with individuals, which may have helped lessen depression, existential tension, and tension and guilt.

Also, there was no significant difference in physical distress. However, physical distress was identified in the one theme that emerged in the open-ended question which was not compatible with the other themes. The response was

"I have had 27 major operations" which indicated physical distress for this individual. The other respondents may not have indicated physical distress for this individual. The other respondents may not have indicated physical distress due to the degree of chronic illnesses and low socioeconomic status of many people in the South. The widows in this study might have compared themselves with neighbors who were in similar or worse situations.

The Neuman Systems Model which served as the framework for this study supported the testimonial statements of the respondents. This model states that an individual is made of five variables: physical, psychological, sociocultural, developmental, and spiritual. An overwhelming number of participants mentioned the variable of spirituality as being affected by the stressor of widowhood. This supports acceptance to the use of Neuman as a framework to guide this study.

Conclusion

Based on the statistical findings of this study, the following conclusions were made:

1. There was no difference in grief experiences based on length of time since bereavement when comparing this group of rural widows.

2. A majority of the widowed women expressed reliance on spirituality.

Implications to Nursing

A number of implications for nursing science were derived from this research. Implications pertinent to nursing research, practice, education, and theory were found.

Practice. Nurse practitioners are in an ideal situation to assess widowed women. Many of these rural widows rely on primary care providers to help them cope with the physical and emotional problems that result with bereavement. Nurse practitioners could utilize an assessment tool similar to the RGEI to determine if there were any particular areas of grieving that were especially problematic for the individual. After determination of problem areas, strategies such as counseling, referral to support groups, or prescription of antidepressants could be implemented.

Education. Nurse practitioner students should be taught in their program of study about patterns of grief reactions. Curricula should incorporate implementation of discussion and explanation of patterns of grief reactions for widowed women. The curricula should include an

assessment of students' own feelings regarding grief reactions in order to better understand grief reactions in individuals served in practice settings.

Theory. The Neuman Systems Model was used in this research study regarding grief experiences of widowed women. The use of the Neuman theory as a framework in this study supports the use of this systems theory to guide future studies related to grief experiences of widowed women to strengthen the lines of defense to prevent other stressors from penetrating to the core of the individual.

Research. The lack of research in the area of grief experiences of widowed women support the need for further research in this area. A review of the literature did not reveal any studies on rural widows' grief experiences. Research needs to be continued in an effort to help widowed women understand patterns of grief reactions, particularly among diverse populations of widows living in various geographic locations. Research such as the current study of investigation could serve as an impetus for further research in this area.

Recommendations

Based on the findings as well as the constraints of this study, the following recommendations were made by the researcher:

Research

1. Replicate the study with a larger sample and more culturally diverse subjects.

2. Replicate the study by allowing more time for data collection and utilizing a different instrument.

3. Replicate the study utilizing qualitative methodology that would explore additional feelings, fears, and coping methods utilized by widowed women.

4. Conduct a comparative study in which differences between widowed men and women grief experiences are examined.

5. Conduct a comparative study in which different age groups of widowed individual grief experiences are examined.

6. Conduct a study that would compare grief experiences of women who experienced sudden bereavement with those who were widowed after an extended illness of a spouse.

7. Conduct a correlational study to determine if there is a relationship between certain variables such as paid work role or spirituality with grief grievances.

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APPENDIX A

REVISED GRIEF EXPERIENCE INVENTORY

Revised Grief Experience Inventory

It has been recognized that survivors of a grief experience are faced with difficulties following the death of a loved one. Currently there are few ways of helping people handle grief.

Below are a series of general statements. Please indicate how much you agree or disagree with them. Be as honest as possible. Remember, there are no right or wrong answers to these questions.

Read each item and decide quickly how you feel about it; then circle the number of the item that best describes your feelings. Put down your first impressions. Please answer every item.

All participants will remain anonymous. Your participation is voluntary.

1 = Strongly agree
2 = Moderately agree
3 = Slightly agree
4 = Slightly disagree
5 = Moderately disagree
6 = Strongly disagree

	AGREE			DISAGREE		
	1	2	3	4	5	6
1. I tend to be irritable with others since the death of my loved one.	___	___	___	___	___	___
2. I frequently experience angry feelings.	___	___	___	___	___	___
3. My arms and legs feel very heavy.	___	___	___	___	___	___
4. I have feelings of guilt because I was spared and the deceased was taken.	___	___	___	___	___	___
5. I feel lost and helpless.	___	___	___	___	___	___
6. I have had frequent headaches since the death.	___	___	___	___	___	___
7. I cry easily.	___	___	___	___	___	___
8. Concentrating on things is difficult.	___	___	___	___	___	___

1 = Strongly Agree
2 = Moderately Agree
3 = Slightly Agree
4 = Slightly Disagree
5 = Moderately Disagree
6 = Strongly Disagree

	AGREE			DISAGREE		
	1	2	3	4	5	6
9. I feel extremely anxious and unsettled.	___	___	___	___	___	___
10. Sometimes I have a strong desire to scream.	___	___	___	___	___	___
11. Life has lost its meaning for me.	___	___		___	___	___
12. I am not feeling healthy.	___	___	___	___	___	___
13. I frequently feel depressed.	___	___	___	___	___	___
14. I have the feeling that I am watching myself go through the motions of living.	___	___	___	___	___	___
15. Life seems empty and barren.	___	___	___	___	___	___
16. I have frequent mood changes.	___	___	___	___	___	___
17. Small problems seem overwhelming.	___	___	___	___	___	___
18. I have lost my appetite.	___	___	___	___	___	___
19. I seem to have lost my energy.	___	___	___	___	___	___
20. I seem to have lost my self-confidence.	___	___	___	___	___	___
21. I am usually unhappy.	___	___	___	___	___	___
22. I am awake most of the night.	___	___	___	___	___	___

APPENDIX B

SHELTON DEMOGRAPHIC SURVEY

Shelton Demographic Survey

1. Age (Please write in years): _____

Choose only one:

2. Current marital status:
   _____ Married
   _____ Widowed
   _____ Divorced

3. Ethnic background
   _____ Caucasian or White
   _____ African American or Black
   _____ Native American or Alaskan Native
   _____ Asian or Pacific Islander
   _____ Other (please list):_____

4. Religious affiliation
   _____ Protestant
   _____ Catholic
   _____ Jewish
   _____ Other (please list):_____
   _____ None

5. I attend religious services at least
   _____ 2 times a week
   _____ 1 time a week
   _____ 2 times a month
   _____ 1 time a month
   _____ 4 times a year
   _____ Other (please list):_____

6. Do you have a close friend or family member with whom you feel able to discuss your feelings?
   _____ Yes
   _____ No

7. Have you ever had a paid job while married?
   _____ Yes
   _____ No

Choose all that apply:

8. Have you been diagnosed with any illness within the following time frame?
   _____ Less than 6 months ago
   _____ 7 months to 1 year ago
   _____ 13 months to 18 months ago
   _____ 19 months to 2 years ago
   _____ Over 2 years to 3 years ago
   _____ Over 3 years to 4 years ago

9. Have you experienced any changes in your life since widowhood?
   _____ Decrease in finances
   _____ Death of a close friend or family member
   _____ Loss or gain of a job
   _____ Moved from where you lived
   _____ Other (please specify):_____
   _____
   _____

10. Is there anything that you would like to share that might help someone else who has lost a spouse? (Use the back if needed)

APPENDIX C

APPROVAL OF THE COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION OF MISSISSIPPI UNIVERSITY FOR WOMEN

MISSISSIPPI UNIVERSITY FOR WOMEN
Columbus, MS 39701

Office of the Vice President for Academic Affairs
Eudora Welty Hall
P.O. Box W-1603
(601) 329-7142

February 23, 1998

Ms. Brenda Shelton
c/o Graduate Program in Nursing
Campus

Dear Ms. Shelton:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research as submitted.

I wish you much success in your research.

Sincerely,

Susan Kupisch

Susan Kupisch, Ph.D.
Vice President
for Academic Affairs

SK:wr

cc: Mr. Jim Davidson
Dr. Mary Pat Curtis

APPENDIX D

INTRODUCTORY LETTER AND INFORMED CONSENT

Dear Participant,

I am a registered nurse and graduate student at Mississippi University for Women. I am conducting a study on grief experiences of widowed women after the death of their spouse. Survivors are faced with difficulties following the death of a husband. This information will help family nurse practitioners better understand grief experiences. This study has been approved by Mississippi University for Women.

I would appreciate your participation in this study. It should take no longer than 10 to 15 minutes to complete. There are no identified individual risks for participation. Be assured that all the information you share will be kept strictly confidential and will be used only for the purposes of the study. No names will be used, and the information will be reported as a group. Your decision to participate in the study is completely voluntary and you may withdraw from the study at any time.

If you would like more information before agreeing to participate in the study, please feel free to contact me at (601) 837-3601. Thank you very much for participating in this study.

Sincerely,

Brenda Shelton, RN, BSN

I have read the above letter. I understand the purpose of the study and agree to participate.

_____ _____

Signature of Participant Date

APPENDIX E

FOLLOW-UP REMINDER POSTCARD

Reminder Postcard

This is a reminder to please complete and mail the Informed Consent, the Shelton Demographic Survey, and the Revised Grief Experience Inventory within the next 2 days. If you have already mailed this information, please disregard this notice.

Thank you for your participation.

Brenda Shelton